therapy with linezolid is that its prolonged use is associated with myelosuppression, but given linezolid's efficacy for treating serious Gram-positive infections, activity against resistant pathogens and equivalent intravenous-to-oral formulations, the benefits of linezolid treatment may outweigh the potential risk of reversible myelosuppression. Neither alternative is mentioned in the article by Bernard *et al.*[1] We believe that any article that intends approaching PTI therapy has to mention all the possible antimicrobial alternatives, and clearly state that the mainstays of therapy are glycopeptides, at least until well-designed trials show evidence of greater benefit of other agents.

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Reply

Louis Bernard[1–3], Pierre Hoffmeyer[1], Mathieu Assal[1], Pierre Vaudaux[2], Jacques Schrenzel[2] and Daniel Lew[2]*

[1]Orthopaedic Clinic and [2]Division of Infectious Diseases, Geneva University Hospital, 24 rue Micheli-du-Crest, 1211 Geneva 14, Switzerland; [3]Division of Infectious Diseases, Garches University Hospital, France

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*Corresponding author. Tel: +41-22-372-33-11; Fax: +41-22-372-77-91: E-mail: daniel.lew@hcuge.ch

Dear Sir,

We thank Parra-Ruiz *et al.*[1] for their useful comments on alternative antimicrobial therapy for orthopaedic prosthetic infections (OPIs) due to methicillin-resistant *Staphylococcus aureus* (MRSA) or *Staphylococcus epidermidis* (MRSE). These infections are protracted and difficult to treat. In our article,[2] we indicate that glycopeptides (vancomycin, teicoplanin) remain the primary drugs that should be used for this indication.[3] The combinations of fusidic acid (or quinolone)[4]–rifampicin[5] and trimethoprim–sulfamethoxazole[6] for susceptible strains have been successfully used in OPI.

We clearly need more new drugs to treat MRSA infection. As discussed by Parra-Ruiz *et al.*,[1] both quinupristin–dalfopristin and linezolid are interesting alternatives, but unfortunately, there is only limited clinical experience with these compounds in osteomyelitis or OPI. Peripheral vein toxicity with quinupristin–dalfopristin and secondary effects upon prolonged therapy with linezolid[7] are serious concerns.

Daptomycin[8] has recently been approved for the therapy of skin and soft tissue infections. Novel glycopeptides such as dalbavancin[9] and a novel cephalosporin active against MRSA activity[10] are promising drugs under development.

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